

**One-time Consent to Release Personally Identifiable Information and Access Public Benefits
from the North Carolina Division of Health Benefits (NC Medicaid)**

(Name of Local Education Agency)

(Address, City, State)

Federal law encourages school districts to seek payment from public insurance programs for some health care services provided at school. Under the Family Education Rights and Privacy Act (FERPA), your consent is required for the school system to release information about your child to the North Carolina Division of Health Benefits (NC Medicaid) in order to access your or your child's public benefits. You are entitled to a copy of any information the school system releases to the state Medicaid program. You may inquire about this program or revoke your consent at any time by contacting (Name) at (contact information).

Your decision to allow the school district to release this information and access your or your child's public benefits will not affect your child's educational program or Medicaid benefits. This consent form is completed for each child receiving evaluations and/or services under any of the following plan types (check all that apply):

- ☐ Individualized Education Program (IEP)
- ☐ Individualized Family Service Plan (IFSP)
- ☐ Section 504 Plan
- ☐ Individualized Health Plan (IHP)
- ☐ Behavior Intervention Plan (BIP)

The funds collected from Medicaid in this school system will be used to:

[INSERT LEA ALLOCATION OF REIMBURSEMENTS HERE. UNDERSTANDING HOW THE LEA USES MEDICAID REIMBURSEMENT TO SUPPORT/IMPROVE EDUCATIONAL PROGRAMS OFTEN HELPS PARENTS SEE THE BENEFIT OF PROVIDING CONSENT.]

Please mark appropriate statement(s), sign and date at the bottom:

- ☐ **I GIVE MY CONSENT** for (Name of Local Education Agency) to access my or my child's NC Medicaid benefits for reimbursement of services provided through the plan(s) marked above. My signature does not give consent to bill my private insurance company. The school system may release the following information to access these public benefits:
- My child's name and Medicaid number;
 - My child's date of birth;
 - My child's service documentation including evaluations;
 - The dates and times services are provided to my child at school;
 - Reports of my child's progress, including therapist notes, progress notes and report cards.

 I understand:

- My child will continue to receive educational services at no cost to me.
- I can revoke my consent at any time and withdrawing my consent does not relieve the school district of its responsibility to ensure all required services are provided at no cost to me.

OR,

- ☐ **I DO NOT GIVE MY CONSENT** for this information to be released. I understand refusing to consent or revoking consent does not change the school district's responsibility to provide educational services at no cost to me.

Child's full name: _____ Parent or guardian name (printed): _____

Parent or guardian's signature: _____

Date signed: ____/____/____